TDMHDD/Board of Probation and Parole (BOPP) Community Treatment Collaborative Guidelines

Administered by the
Tennessee Department of Mental Health
and Developmental Disabilities
(TDMHDD)
Division of Alcohol and Drug Abuse Services (DADAS)
5th Floor, Cordell Hull Building
425 5th Avenue North
Nashville, TN 37243
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I. Program Description:

Funded through an interagency agreement between BOPP and TDMHDD, the TDMHDD/BOPP Community Treatment Collaborative is a collaborative effort to divert at risk probation and parole technical violators with substance abuse and co-occurring disorders from returning to state prison.

At risk violators reside throughout the state. Consequently services must be broadly and quickly available to be successful in meeting diversion goals and the substance abuse and co-occurring treatment needs of BOPP consumers. An individual service cap of $5000 has been set for BOPP consumers and this population has been added to the list of DADAS priority populations (see section Referrals). No individual agency cap will be applied at this time. This may change at some future point, depending on availability of funding.

The TDMHDD/BOPP Community Treatment Collaborative requires a collaborative treatment approach which engages consumer, provider, BOPP staff and other supports. At its foundation, the TDMHDD/BOPP Community Treatment Collaborative acknowledges drug addiction as a brain disease that affects behavior and that recovery from drug addiction requires effective treatment, followed by management of the problem over time.

II. Program Contact:

Maggie Throckmorton
Director of Special Projects
Division of Alcohol and Drug Abuse Services
Tennessee Department of Mental Health and Developmental Disabilities
Direct Office Line: 615-532-3025
Email: maggie.throckmorton@tn.gov

III. Criteria for Placement, Assessment and Referrals to Treatment:

A. Criteria:

Following is the criteria for placement in the TDMHDD/BOPP Community Treatment Collaborative:

- The consumer is under the supervision of BOPP and at risk for violation, as determined by BOPP;
- Level of Service/Case Management Inventory (LS/CMI) indicates a need for substance abuse or co-occurring disorders treatment and the LS/CMI risk level is appropriate for community based treatment;
- Addiction Severity Index (ASI) indicates a need for treatment;
- The consumer is referred to the provider agency by BOPP;
- If a sex offender, the consumer is eligible for treatment services in facilities that do not violate the consumer's conditions for probation and/or parole (e.g. facility is in proximity of school, adolescent treatment services are delivered within treatment facility); and
- If the consumer is a juvenile that has been tried and convicted as an adult, but chronologically is under the age of eighteen, the consumer is eligible to receive adolescent treatment services through the TDMHDD/BOPP Community Treatment Collaborative. Treatment for adolescents under the supervision of BOPP must be coordinated through the contact in Section II.

B. Assessment:

BOPP Officers in conjunction with BOPP Psychiatric Social Workers across the State will identify consumers in need of substance abuse and co-occurring disorders treatment, using specific assessment tools:

Level of Service/Case Management Inventory (LS/CMI):

BOPP staff is trained in the administration of the Level of Service/Case Management Inventory (LS/CMI). This assessment measures the risk and need factors of late adolescent and adult offenders in addition to being a fully functioning case management tool. This single application provides all the essential tools needed to aid professionals in the treatment planning and management of offenders in justice, forensic, correctional, prevention and related agencies.

TDMHDD/BOPP Community Treatment Collaborative providers can review consumer LS/CMI results through a web-based access point at: https://www.mhsassessments.com/nalscmi/login.aspx. Individual login and passwords will be issued to approved TDMHDD/BOPP Community Treatment Collaborative providers after submission of the completed **BOPP LS/CMI Access Requests Form (see Attachment 1)**. Login access is restricted to two designated staff per agency. **In the event designated staff leaves the agency, immediately notify the program contact listed in Section II of this document so that access rights can be terminated.**

About the LS/CMI

The LS/CMI system's multi-component evaluation involves obtaining information from many sources about many aspects of the offender's life. Offenders are first interviewed to gather information so the assessor can accurately complete the assessment. Assessors can also indicate areas of offender strength, which could serve as protective factors. Ten additional comprehensive sections have been added. Several of these sections assess mitigating or aggravating factors that can affect risk/need levels, such as a section about concerns specific to incarcerated offenders. Other sections document a professional or administrative override. The find sections deal exclusively with case management considerations, including assessing responsivity concerns to help offenders rehabilitate.

Once offender information has been gathered, the assessor can then begin the assessment process. Termed by researchers as the "Big Eight", Section 1 contains the following subcomponents due to their well evaluated predictivity and applicability.

- Criminal History (8 items)
- Education/Employment (9 items)
- Family/Marital (4 items)
- Leisure/Recreation (2 items)
- Companions (4 items)
- Alcohol/Drug Problem (8 items)

Once these items have been rated, an offender's score is compared to a normative group. Norms are provided for gender and type of offenders (i.e. community, institutional). Tables show the probability of inmate and community offenders recidivating based on offender risk level. Remaining sections of the LS/CMI are not scored; instead they yield valuable qualitative offender data, such as past victimization that may have influenced behavior. Items also consider concerns relevant to providing offender programming, such as cultural concerns relevant to providing offender programming and the offender's intellectual capacity.

Addiction Severity Index (ASI)

BOPP Psychiatric Social Workers have been trained by DADAS staff in the administration of the ASI. BOPP Psychiatric Social Workers will generally administer the ASI to BOPP consumers using the DENS ASI in TN-WITS, transferring this information with the treatment referral in TN- WITS to the provider agency. BOPP Psychiatric Social Workers may also refer the consumer to the provider agency for the ASI. The consumer is only eligible to receive one assessment through the TDMHDD/BOPP Community Treatment Collaborative.

American Society of Addiction Medicine Patient Placement Criteria (ASAM)

Once referred to treatment, the BOPP consumer will be administered the ASAM by the treatment provider and referred to the appropriate level of care.

C. Referrals to Treatment:

1. BOPP Consumer identified as at risk for violation, in need of substance abuse or co-occurring disorders treatment and appropriate for community based services, as indicated by the LS/CMI and ASI;
2. BOPP Psychiatric Social Worker identifies TDMHDD/BOPP Community Treatment Collaborative Provider that is a) in close geographic proximity to the consumer and/or b) has the appropriate service type to meet consumer need;
3. BOPP Psychiatric Social Worker calls the treatment provider's TDMHDD/BOPP Community Treatment Collaborative Contact and obtains an intake date; and
4. BOPP Psychiatric Social Worker if competing ASI, will transfer the client to the provider agency in TN-WITS and obtain and forward appropriate consumer releases to the provider agency.

DADAS has identified priority populations. If the BOPP Consumer meets the criteria for the priority populations 1-3, that ranking supersedes their ranking as a BOPP Consumer.

DADAS Priority Populations listed in sequential order of priority:

1. Pregnant Intravenous Drug Using Women
2. Pregnant Women with a Substance Use Disorder
3. HIV/AID Intravenous Drug Use
4. BOPP Consumers

See Attachment 2, Referral Flow Chart

D. Criteria, Assessment and Referral Disputes:

The TDMHDD/BOPP Community Treatment Collaborative is a collaborative treatment approach which engages the BOPP Officer, BOPP Psychiatric Social Worker, Treatment Provider, Consumer and other supports in the consumers treatment planning, progress and recovery.

This approach is intended to diminish the likelihood of inappropriate referrals and better treatment outcomes. Should there be a referral dispute which cannot be quickly resolved between the BOPP Officer, BOPP Psychiatric Social Worker and the treatment provider; the matter should be referred to the Program Contact listed in Section II via email by the consumer's BOPP Psychiatric Social Worker.

The dispute referral should contain the following information:

- Initials of Consumer
- Consumer Demographics (age, gender, etc)
- Type of Offense
- BOPP Psychiatric Social Worker Name
- BOPP Officer Name
- Treatment Agency
- Treatment Agency Contact Name
- Nature of Dispute to include pertinent clinical information

The dispute will then be reviewed by the Program Development Team (PDT), comprised of the following:

- BOPP Director of Field Services
- BOPP Assistant Director of Field Services
- DADAS Director of Special Projects
- DADAS Director of Treatment and Recovery Support Services

The goal of the PDT is to find an equitable solution that best meets the need of the consumer. The dispute will be reviewed within **twenty-four** hours of referral. BOPP staff and treatment providers may be engaged to answer additional questions prior to a dispute resolution. All parties will be advised of the decision of the PDT.

IV. Principles of Intake and Collaborative Substance Abuse Treatment

A. Intake into Treatment

Once the consumer has been referred to treatment and an intake date determined:

Intake Responsibilities of the BOPP Psychiatric Social Worker:

Advise the consumer of the following using the **TDMHDD/BOPP Community Treatment Collaborative Referral Form, Attachment 3:**

1. Intake Date and Time
2. BOPP Psychiatric Social Worker Name and Contact Phone Number
3. Treatment Provider Agency Name
4. Address
5. Contact Name
6. Contact Phone Number
7. Facility Hours
8. Other intake information as indicated by the provider agency

Intake Responsibilities of the BOPP Consumer:

1. Arrive on scheduled intake date and time at treatment provider agency; and
2. Contact BOPP Psychiatric Social Worker upon arrival at treatment provider agency.

Intake Responsibilities of Treatment Provider:

1. Allow consumer to make contact with BOPP Psychiatric Social Worker to advise them of arrival at treatment facility; and
2. Advise BOPP Psychiatric Social Worker **immediately** if the consumer is a no-show for their intake appointment.

B. National Institute on Drug Abuse (NIDA), Principles of Drug Abuse Treatment for Criminal Justice Populations

1. **Drug addiction is a brain disease that affects behavior.** Drug addiction has well-recognized cognitive, behavioral and physiological characteristics that contribute to continued use of drugs despite the harmful consequences. Scientists have also found that chronic drug abuse alters the brain's anatomy and chemistry and that these changes can last for months or years after the individual has stopped using drugs. This transformation may help explain why addicts are at a high risk of relapse to drug abuse even after long periods of abstinence and why they persist in seeking drugs despite deleterious consequences.

2. **Recovery from drug addiction requires effective treatment followed by management of the problem over time.** Drug addiction is a serious problem that can be treated and managed throughout its course. Effective drug abuse treatment engages participants in a therapeutic process, retains them in treatment for an appropriate length of time, and helps them learn to maintain abstinence over time. Multiple episodes of treatment may be required. Outcomes for drug abusing offenders in the community can be improved by monitoring drug use and by encouraging continued participation in treatment.

3. **Treatment must last long enough to produce stable behavioral changes.** In treatment, the drug abuser is taught to break old patterns of thinking and behaving and to learn new skills for avoiding drug use and criminal behavior. Individuals with severe drug problems and co-occurring disorders typically need longer treatment (e.g., a minimum of 3 months) and more comprehensive services. Early in treatment, the drug abuser begins a therapeutic process of change. In later stages, he or she addresses other problems related to drug abuse and learns how to manage the problem.

4. **Assessment is the first step in treatment.** A history of drug or alcohol use may suggest the need to conduct a comprehensive assessment to determine the nature and extent of an individual's drug problems; establish whether problems exist in other areas that may affect recovery; and enable the formulation of an appropriate treatment plan. Personality disorders and other mental health problems are prevalent in offender populations; therefore, comprehensive, assessments should include mental health evaluations with treatment planning for these problems.

5. **Tailoring services to fit the needs of the individual is an important part of effective drug abuse treatment for criminal justice populations.** Individuals differ in terms of age, gender, ethnicity and culture, problem severity, recovery stage, and level of supervision needed. Individuals also respond differently to different treatment approaches and treatment providers. In general, drug treatment should address issues of motivation, problem solving, and skill-building for resisting drug use and criminal behavior. Lessons aimed at supplanting drug use and criminal activities with constructive activities and at understanding the consequences of one's behavior are also important to include. Treatment interventions can facilitate the development of healthy interpersonal relationships and improve the participant's ability to interact with family, peers, and others in the community.

6. **Drug use during treatment should be carefully monitored.** Individuals trying to recover from drug addiction may experience a relapse, or return to drug use. Triggers for drug relapse are varied; common triggers include mental stress and associations with peers, and social situations linked to drug use. An undetected relapse can progress to serious drug abuse, but detected use can present opportunities for therapeutic intervention. Monitoring drug use through urinalysis or other objective methods, as part of treatment or criminal justice supervision, provides a basis for assessing and providing feedback on the participant's treatment progress. It also provides opportunities to intervene to change unconstructive behavior---determining rewards and sanctions to facilitate change and modifying treatment plans according to progress.

7. **Treatment should target factors that are associated with criminal behavior.** "Criminal thinking" is a combination of attitudes and beliefs that support a criminal lifestyle and criminal behavior. These can include feeling entitled to have things one's own way, feeling that one's criminal behavior is justified, failing to be responsible for one's actions, and consistently failing to anticipate or appreciate the consequences of one's behavior. This pattern of thinking often contributes to drug use and criminal behavior. Treatment that provides specific cognitive skills training to help individuals recognize errors in judgment that lead to drug abuse and criminal behavior may improve outcomes.

8. **Criminal justice supervision should incorporate treatment planning for drug abusing offenders, and treatment providers should be aware of correctional supervision requirements.** The coordination of drug abuse treatment with correctional planning can encourage participation in drug abuse treatment and can help treatment providers incorporate correctional requirements as treatment goals. Treatment providers should collaborate with criminal justice staff to evaluate each individual's treatment plan and ensure that it meets correctional supervision requirements, as well as that person's changing needs, which may include housing and childcare; medical, psychiatric, and social support services; and vocational and employment assistance. For offenders with drug abuse problems, planning should incorporate the transition to community-based treatment and links to appropriate post release services to improve the success of drug treatment and re-entry. Abstinence requirements may necessitate a rapid clinical response, such as more counseling, targeted intervention, or increased medication, to prevent relapse. Ongoing coordination between treatment providers and courts or parole and probation officers is important in addressing the complex needs of these re-entering individuals.

9. **Continuity of care is essential for drug abusers re-entering the community.** Those who complete prison-based treatment and continue with treatment in the community have the best outcomes. Continuing drug abuse treatment helps the recently released offender deal with problems that become relevant only at re-entry, such as learning to handle situations that could lead to relapse, learning how to live drug-free in the community and developing a drug free peer support network. Treatment in prison or jail can begin a process of therapeutic change, resulting in reduced drug use and criminal behavior post incarceration. Continuing drug treatment in the community is essential in sustaining these gains.

10. **A balance of rewards and sanctions encourages prosocial behavior and treatment participation.** When providing correctional supervision of individuals participating in drug abuse treatment, it is important to reinforce positive behavior. Nonmonetary "social reinforcers" such as recognition for progress or sincere effort can be effective, as can graduated sanctions that are consistent, predictable, and clear responses to noncompliant behavior. Generally, less punitive responses are used for early and less serious noncompliance with increasingly severe sanctions

issuing from continued problem behavior. Rewards and sanctions are most likely to have the desired effect when they are perceived as fair and when they swiftly follow the targeted behavior.

11. **Offenders with co-occurring drug abuse and mental health problems often require an integrated treatment approach.** High rates of mental health problems are found both in offender populations and in those with substance abuse problems. Drug abuse treatment can sometimes address depression, anxiety, and other mental health problems. Personality, cognitive, and other serious mental disorders can be difficult to treat and may disrupt drug treatment. The presence of co-occurring disorders may require an integrated approach that combines drug abuse treatment with psychiatric treatment, including the use of medication. Individuals with either a substance abuse or mental health problem should be assessed for the presence of the other.

12. **Medications are an important part of treatment for many drug abusing offenders.** Medicines such as methadone and buprenorphine for heroin addiction have been shown to help normalize brain function and should be made available to individuals who could benefit from them. Effective use of medications can also be instrumental in enabling people with co-occurring mental health problems to function successfully in society. Behavioral strategies can increase adherence to medication regimens.

13. **Treatment planning for drug abusing offenders who are living in or re-entering the community should include strategies to prevent and treat serious, chronic medical conditions, such as HIV/AIDS, hepatitis B and C, and tuberculosis.** The rates of infectious diseases, such as hepatitis, tuberculosis and HIV/AIDS, are higher in drug abusers, incarcerated offenders, and offenders under community supervision than in the general population. Infectious diseases affect not just the offender, but also the criminal justice system and the wider community. Consistent with Federal and State laws, drug-involved offenders should be offered testing for infectious diseases and receive counseling on their health status and on ways to modify risk behaviors. Probation and parole officers who monitor offenders with serious medical conditions should link them with appropriate healthcare services, encourage compliance with medical treatment, and re-establish their eligibility for public health services (e.g., Medicaid, county health departments) before release from prison or jail.

C. Collaborative Treatment Team Approach

Providers must describe in the TDMHDD/BOPP Community Treatment Collaborative application a collaborative treatment approach which at a minimum includes persons noted below in telephone meetings and consultation:

(1) Consumer;

(2) BOPP Officer;

(3) BOPP Psychiatric Social Worker;

(4) Program Provider;

(5) Family/Significant Others; and

(6) Other Supports as indicated.

D. Communicating Consumer Progress and Treatment Compliance

Weekly Telephone Communication:

Treatment Provider Progress Meeting Responsibilities:

1. Schedule weekly telephone progress meetings with the BOPP Psychiatric Social Worker and BOPP Officer and other consumer supports; and
2. Telephone progress meetings should discuss:

    - Consumer Treatment Compliance and Progress; and
    - Ongoing consumer treatment and recovery support needs to include planning and referrals to services.

BOPP Officer and BOPP Psychiatric Social Worker Progress Meeting Responsibilities:

1. Participate in meetings;
2. Assist in meeting consumer treatment and recovery support needs to include planning and referrals to services; and
3. Make referrals to programming to address other criminogenic behaviors to include but not limited to BOPP group programming or Cognitive Behavioral Therapy *(e.g Thinking for Change.)*

Face to Face Meetings:

Face-to-face meetings that involve the consumer, BOPP Psychiatric Social Worker, and Treatment Provider are encouraged when consumer treatment progress or compliance warrants a more intensive level of collaboration.

Non-Compliance and Termination from Treatment Program

Termination from treatment for non-compliance should be a collaborative decision making process that involves the BOPP Officer, BOPP Psychiatric Social Worker and Treatment Provider. If the treatment team decides to terminate the consumer due to treatment non-compliance, it is the responsibility of the treatment provider to notify the consumer in writing, listing the reasons for termination, and carbon copying the BOPP Officer and Psychiatric Social Worker.

In the event a BOPP consumer leaves a treatment program prior to being discharged by the treatment provider, **it is the obligation of the treatment provider to immediately notify the BOPP Officer and BOPP Psychiatric Social Worker**

V. Consumer Cap Service Rates

Consumer Cap:

The maximum individual consumer cap in a fiscal year is $5000 per consumer. Service utilization will be tracked in TN-WITS. Any services beyond the $5000 consumer cap will not be authorized for payment. No individual agency cap will be applied at this time. This may change at some future point, depending on availability of funding.

Service Descriptions and Rates:

Service Description	Maximum Rate
Clinical Assessment to determine appropriate treatment services for eligible individuals. This must include an Addiction Severity Index (ASI) to determine problem severity. American Society of Addiction Medicine Patient Placement Criteria, Second Edition (ASAM PPC-2R) criteria must be used if the ASI indicates the need for clinical treatment. Staff must be Qualified Alcohol and Drug Abuse (A&D) personnel as defined by Tennessee licensure (staff in licensed A&D treatment facilities are qualified based on facility license) and must have completed training by a qualified trainer in the use of ASI and ASAM.	$50.00 per assessment, if administered by the treatment provider. **In most instances the assessment will be administered by the BOPP Psychiatric Social Worker.**
Outpatient Treatment – Level 1 – Individual and Group, which provides a wide range of nonresidential services for individuals with a primary or secondary alcohol or other drug abuse or dependency diagnosis which allow the persons receiving the services to function as they go about their daily lives in the community. Services include individual therapy, group therapy, family therapy or any combination of such counseling services that are usually scheduled on a periodic basis. Group size must be a minimum of six (6) individuals and no more than twelve (12) individuals for a valid group session unless otherwise approved in writing by the State. Only one (1) outpatient service per day per client is valid. A valid individual session must be a minimum of fifty (50) minutes and a valid group session must be a minimum of ninety (90) minutes, excluding administrative time.	$50.00 per individual session (fifty (50) minute session); $25.00 per group session (ninety (90) minute session)
Intensive Outpatient (IOP) – Level II.1, which is highly structured and intensive. These services may include individual therapy, group therapy, family therapy or any combination of such counseling services. The services must meet ASAM-PPC-2R patient placement criteria. This service must provide between nine (9) and nineteen (19) hours per week of clinically intensive programming, and it must meet a minimum of four (4) days per week for seventeen (17) weeks. Per day is defined as three (3) hours of treatment services, with a maximum weekly billing of six (6) days. The group size must be a minimum of six (6) individuals and no more than twelve (12) individuals for a valid group session unless otherwise approved in writing by the State. This service may only be provided by Tennessee licensed treatment providers.	$55.00 per day
Adult Partial Hospitalization - Level II.5, which is a structured nonresidential treatment program for individuals with a primary or secondary alcohol or other drug abuse or dependency diagnosis that generally provides twenty (20) or more hours of clinically intensive programming per week based on individual needs. Group size must be a minimum of six (6) clients and no more than twelve (12) clients for a valid group session unless otherwise approved in writing by the State. A valid unit of service must be a minimum of four (4) hours per day. This service provides an alternative to residential treatment for persons with substance abuse related disorders who cannot be treated exclusively in an outpatient setting. An intensive partial hospitalization service is operated to provide the individual with an intensive and ongoing treatment program designed to assist him/her to modify problem	$80.00 per day

behavior and to acquire the skills necessary to live as independently as possible and/or minimize his/her deterioration in the community.	
Adult Clinically-Managed Detoxification Services (Social Detoxification) – Level III.2-D, which is a seven (7) days a week, twenty-four (24) hours a day residential social setting detoxification to treat individuals with a primary or secondary alcohol or other drug abuse or dependency diagnosis. Services take place in a supportive environment and are designed to facilitate the withdrawal of the alcohol and/or drug dependent person and could include the limited use of medication. The term "detoxification" may include provision of individual therapy, group therapy, family therapy or any combination of such counseling services. Services may also include any necessary testing or evaluation to determine if individuals meet the agency admission criteria.	$165.00 per day
Adult Clinically-Managed Low-Intensity Residential Services (Residential Rehabilitation-Low/Halfway House) - Level III.1, which provide a structured residential treatment program for individuals with a primary or secondary alcohol or other drug abuse or dependency diagnosis. Services include provision of individual counseling, group counseling, family counseling, alcohol and drug abuse education, or any combination of such services. These activities include a minimum of one (1) counseling contact and one (1) educational lecture or seminar per week. Narcotics Anonymous and Alcoholics Anonymous groups are not considered as lectures or seminars.	$50.00 per day
Adult Clinically-Managed Medium-Intensity Residential Rehabilitation Services – Level III.3, which are structured residential treatment programs for individuals with a primary or secondary alcohol or other drug abuse or dependency diagnosis who need less-intense, slower-paced, and longer term treatment. Services include provision of individual therapy, group therapy, family therapy or any combination of such counseling services and are designed to restore the severely dysfunctional alcohol and/or drug dependent person to levels of functioning appropriate to that individual. Services may be provided in a hospital or a residential setting and are not appropriate for persons experiencing withdrawal symptoms. An essential aspect of residential rehabilitation is the ongoing structured use of therapy to achieve the goal of rehabilitation. This therapy includes a minimum of five (5) counseling contacts per week and a minimum of five (5) lectures or seminars per week. Narcotics Anonymous and Alcoholics Anonymous groups are not considered as lectures or seminars.	$110.00 per day
Adult Clinically-Managed High-Intensity Residential Rehabilitation Services – Level III.5, which are structured residential treatment programs for individuals with a primary or secondary alcohol or other drug abuse or dependency diagnosis who need more-intense, faster-paced, and shorter term treatment. Services include provision of individual therapy, group therapy, family therapy or any combination of such counseling services and are designed to restore the severely dysfunctional alcohol and/or drug dependent person to levels of functioning appropriate to that individual. The services may be provided in a hospital or a residential setting and are not appropriate for persons	$130.00 per day

experiencing withdrawal symptoms. An essential aspect of residential rehabilitation is the ongoing structured use of therapy to achieve the goal of rehabilitation. This therapy includes a minimum of five (5) counseling contacts per week and a minimum of five (5) lectures or seminars per week. Narcotics Anonymous and Alcoholics Anonymous groups are not considered as lectures or seminars.	
Adult Medically-Monitored Detoxification Services (Medical Detoxification) - Level III.7-D, which is a seven (7) days a week, twenty-four (24) hours a day treatment in a residential facility with services delivered by medical and nursing professionals to individuals with a primary or secondary alcohol or other drug abuse or dependency diagnosis. The Medical Detoxification residential facility will provide medically-supervised evaluation and withdrawal management under a defined set of physician-approved policies and physician-monitored procedures or clinical protocols. Individual therapy, group therapy, family therapy or any combination of such counseling services may be included.	$150.00 per day

Print Form

TENNESSEE BOARD OF PROBATION AND PAROLE
LEVELS OF SERVICE / CASE MANAGEMENT INVENTORY (LS/CMI)
ACCESS REQUEST

PART I. **SUPERVISOR INFORMATION**

Supervisor Name: _____ ID _____

Agency: _____ Work Site: _____

Work Phone: _____

Email Address: _____

PART II. **USER INFORMATION**

Requested For: _____ ID _____

Agency: _____ Work Site _____

Work Phone: _____

Email Address: _____

PART III. **ACCESS LEVEL REQUESTED**

SECURITY ADMIN: _____ **USER ADMIN** _____

OFFENDER ADMIN: _____ **VIEW ONLY** _____

PART IV. **TRAINING CERTIFICATION/AUTHORIZATION** **(not required for view only requests)**

Date Completed: _____

TRAINING LEVEL: **FULL LS/CMI** _____ **DATA ENTRY ONLY** _____

Certified/Authorized by: _____ ID _____

Work Site: _____ Work Phone _____

Email Address: _____

PART V. **SUBMITTED BY INFORMATION** Date Submitted: _____

Submitted by: _____ ID _____

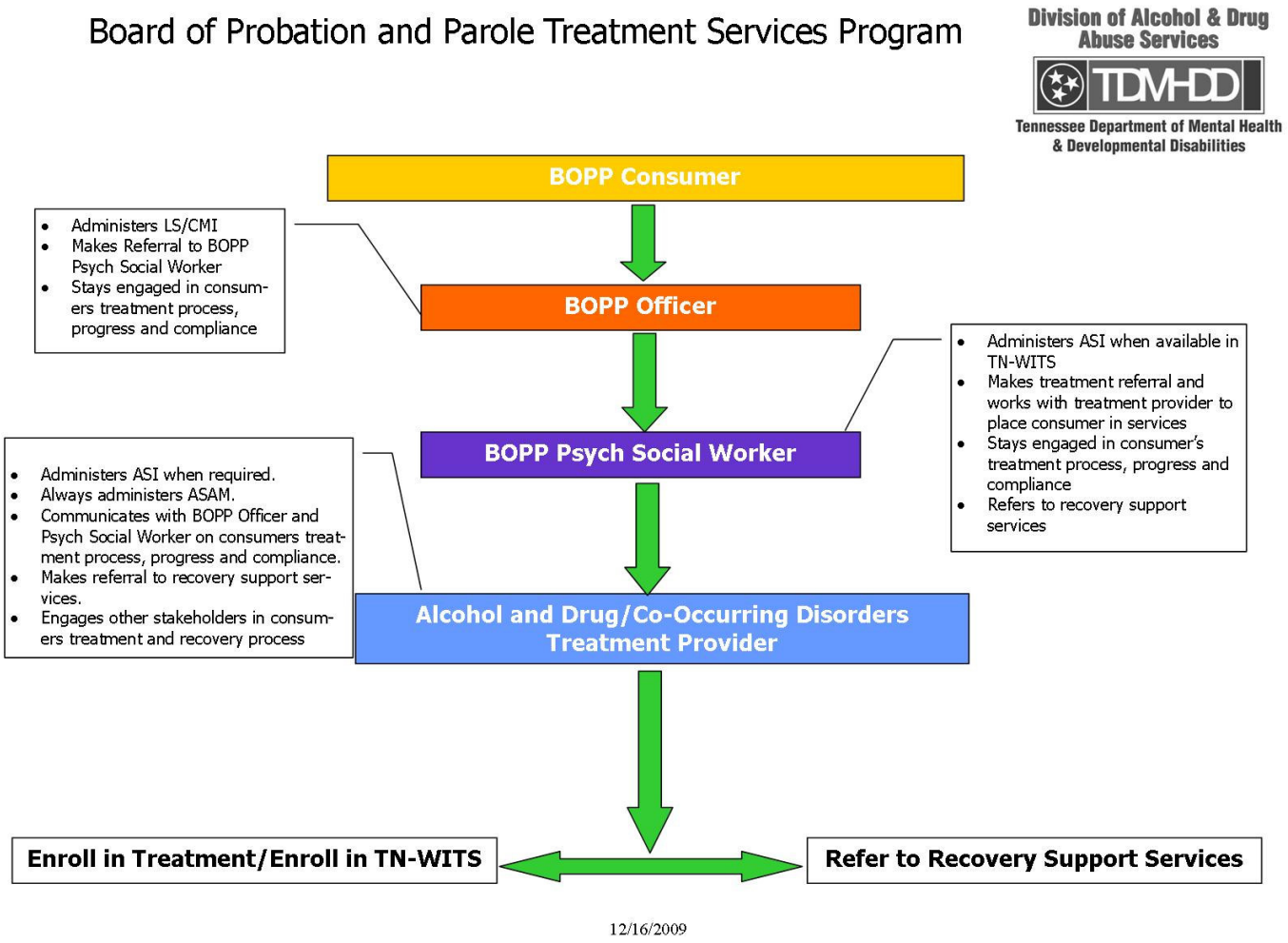
Work Site: _____ Work Phone _____

PART VI. ***For Help Desk Usage Only*** Training Access Inactivated _____

BP Pending

Submit by Email

Attachment 2, Referral Flow Chart



Attachment 3, TDMHDD/BOPP Community Treatment Collaborative Referral Form

TDMHDD/BOPP Community Treatment Collaborative Referral
Tennessee Department of Mental Health and Developmental Disabilities
Division of Alcohol and Drug Abuse Services

Client Name							
Intake Date		Intake Time					
BOPP Psychiatric Social Worker Name				Contact Phone Number			
Treatment Provider Agency Name				Facility Hours			
Address		City		State		Zip	
Contact Name				Contact Phone Number			
Comments:							

BOPP DISTRICT PSYCHIATRIC SOCIAL WORKERS					
DISTRICT	**NAME**	**TITLE**	**PHONE #**	**FAX #**	**STREET ADDRESS**
1	Megumi Britt Megumi.Britt@tn.gov	PSY SOC WORKER 1	423-279-3200	423-279-3222	BLOUNTVILLE OFFICE 1329 HIGHWAY 394 P.O. BOX 425 BLOUNTVILLE, TN 37617
1	Katherine M. Connolly Katherin.Connolly@tn.gov	PSY SOC WORKER 1	434-6800/134	423-434-6830	JOHNSON CITY OFFICE 196 MONTGOMERY STREET JOHNSON CITY, TN 37604
2	Shannon W. Brown Shannon.X.Brown@tn.gov	PSY SOC WORKER 1	865-582-2074	865-594-7125	KNOXVILLE OFFICE 1426 ELM STREET KNOXVILLE, TN 37921 MAILING ADDRESS: P.O. BOX 3190 KNOXVILLE, TN 37927
2	Julia B. Duff Julia.Duff@tn.gov	PSY SOC WORKER 1	865-457-4995	865-463-0784	CLINTON OFFICE 110 CENTER STAGE BLVD. CLINTON, TN 37716
2	Donald W. Howard Donald.W.Howard@tn.gov	PSY SOC WORKER 1	423-587-7023	423-587-7059	MORRISTOWN OFFICE 209 EAST MAIN STREET MORRISTOWN, TN 37814
2	Marion Rieger Marion.Rieger@tn.gov	PSY SOC WORKER 1	865-981-2369/125		MARYVILLE OFFICE 304 HOME AVENUE MARYVILLE, TN 37801
3	Tanya L. Pace Tanya.Pace@tn.gov	PSY SOC WORKER 1	423-634-6333/113	423-634-6365	CHATTANOOGA OFFICE 540 MCCALLIE AVE., STE 250 CHATTANOOGA, TN 37402
3	Donna Roe Donna.Roe@tn.gov	PSY SOC WORKER 1	931-473-7213	931-473-8206	MCMINNVILLE OFFICE 102 MULLICAN STREET MCMINNVILLE, TN 37110
3	Patricia Shaw Patricia.Shaw@tn.gov	PSY SOC WORKER 1	423-478-0313	423-478-4984	CLEVELAND OFFICE 950 STAR-VUE DRIVE SW, STE 2 CLEVELAND, TN 37311
4	Larissa A. Hutchings Larissa.Hutchings@tn.gov	PSY SOC WORKER 1	615-253-253-7400	615-242-2114	NASHVILLE OFFICE 220 BLANTON AVENUE NASHVILLE, TN 37217
5	Donna Woodson Donna.X.Woodson@tn.gov	PSY SOC WORKER 1	615-898-8030/1023	615-848-5110	MURFREESBORO OFFICE 1711 OLD FORT PKWY, STE C MURFREESBORO, TN 37129
6	Carolyn Johnson Carolyn.Johnson@tn.gov	PSY SOC WORKER 1	731-984-9805	731-984-7495	JACKSON OFFICE 1661 HOLLYWOOD DRIVE JACKSON, TN 38305
7	Naricia Futrell Naricia.Futrell@tn.gov	PSY SOC WORKER 1	901-344-5021	901-353-1259	SOUTH MEMPHIS OFFICE 3358 SOUTH THIRD STREET MEMPHIS, TN 38109
7	Selena Smith Selena.Smith@tn.gov	PSY SOC WORKER 1	901-354-3746	901-353-1259	NORTH OFFICE & RESOURCE CENTER 2584 OVERTON CROSSING MEMPHIS, TN 38127
8	VACANT	PSY SOC WORKER 1	931-648-5550	931-648-5565	CLARKSVILLE BOPP OFFICE 100 PROVIDENCE BLVD, SUITE A CLARKSVILLE, TN 37042